

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

14955

State File No.

FILED JUN 1 1955

BIRTH NO. _____		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>45</u>	
1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. LENGTH OF STAY (in this place) <u>22 YEARS</u>		c. CITY OR TOWN <u>Excelsior Springs</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>234 Old Orchard</u>				f. STREET ADDRESS (If rural, give location) <u>234 Old Orchard 600 20</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>DANA</u>		b. (Middle) <u>D.</u>		c. (Last) <u>HERRELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 14 1955</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>		8. DATE OF BIRTH <u>AUG. 16, 1887</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DENTISTRY</u>		9. AGE (In years last birthday) <u>67</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>URICH, MO.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>GEORGE ANNA BOWDEN</u>		14. NAME OF HUSBAND OR WIFE <u>DELL F. HERRELL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>DELL HERRELL 234 OLD ORCHARD EXCELSIOR SPRINGS, MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac deficiency - Coronary thrombosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Patient was a diabetic.</u> DUE TO (c) <u>H2O1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to <u>April 14, 1953</u> , that I last saw the deceased alive on <u>April 14, 1953</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Barbara Mawson, M.D.</u>				23b. ADDRESS <u>101 North Embury Ave</u>		23c. DATE SIGNED <u>4-14-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>4-16-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MASONIC</u>		24d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS MO.</u>	
DATE REC'D BY LOCAL REG. <u>5/14/55</u>		REGISTRAR'S SIGNATURE <u>Barbarine Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Blaise Prichard</u>		ADDRESS <u>Excelsior Springs Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 45

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.